Health Care Reform in Maine:
How Does Medicaid Financing Fit In?

Report to the Blue Ribbon Commission on Dirigo Health

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Executive Summary

Medicaid, or MaineCare as it is called in Maine, is a key component of Maine's health care system and a key partner to the Dirigo Health initiative. This report reviews the basics of Medicaid, its relationship with DirigoChoice, and options for moving forward.

Key findings:

- **MaineCare has contributed significantly over the years to Maine's efforts to reduce the uninsurance rate among its residents.**

MaineCare is the source of coverage for more than one out of five Mainers and contributes to an uninsured rate that is lower in Maine than in most states in the country, particularly for children.

- **MaineCare is of particular value both because it provides comprehensive and affordable coverage to enrollees and because it offers Maine significant federal financial support to help reach its coverage goals.**

For every $100 that Maine spends with its own funds through Medicaid, the federal government contributes an additional $170 in federal funds. Medicaid's federal contributions have been key to virtually every state's efforts to expand coverage.

- **Dirigo Health and MaineCare work together in a unique and innovative way**.

Employees and family members who are participating in DirigoChoice and who are eligible for MaineCare are enrolled in DirigoChoice Group A; they are DirigoChoice enrollees and they are MaineCare enrollees. As members of Group A, they receive a 100% discount on their DirigoChoice contributions. They have access to the same plan and the same providers as other DirigoChoice participants, and the providers serving all groups of DirigoChoice participants are paid the same Anthem rates. The design seeks to assure that an employee maintains coverage and stable provider relationships when an employee's income rises or falls and that all employees can participate in the employer's plan, regardless of income. If family income changes, their discount group may change but they remain covered through DirigoChoice. This structure allows Maine to claim federal matching payments for the cost of covering those DirigoChoice employees and family members who are enrolled in MaineCare (although federal payments have been on hold pending further review). Federal support can help Dirigo Health achieve its important goals.

- **There may be ways to realize even stronger benefits from the current structure.**

Currently, only a small portion of DirigoChoice employees and dependents are enrolled in Group A (100% discount) while nearly half of all Dirigo Health enrollees are in Group B. The question to consider is whether certain policies or practices may be causing people who are eligible for Group A to end up in Group B (80% discount)and whether policies, procedures, or marketing changes could change what appears to be a skewed distribution. While more analysis is needed to identify the specific causes of the low participation within Group A, some options to consider include:

  - *Improving marketing and enrollment procedures.* Group A participation may be low due to DirigoChoice marketing patterns and practices, lack of information or explanation to employers and employees about Group A benefits and eligibility, and perhaps even active discouragement. When individuals eligible for Group A do not enroll in Group A, they are losing out on the steeper discount that can help them afford and maintain their coverage, and the state could be losing out on potential federal matching payments.

  - *Changing the asset rules or asset rule procedures.* Currently, in order to qualify for the Group A discount (DirigoChoice/MaineCare), adults must show that the value of their assets (e.g., property, bank accounts) fall below certain limits. The asset test can create barriers for people, either because they have resources above the limit or because the paperwork requirements may be difficult and burdensome to meet. The asset requirement is a MaineCare rule. The operational and fiscal impact of a change in the rules or procedures would need to be considered.

- **Other ways to structure the relationship between DirigoChoice and MaineCare are possible, but these models would not provide nearly the same level of federal support that the current structure has the potential to offer.**

Other approaches, such as "premium assistance" might be useful in MaineCare generally to help bring down per member costs for MaineCare enrollees who have access to employer-sponsored insurance, but as a strategy to complement Dirigo Health, premium assistance will not to provide as seamless a system or as much federal support as the current system has the potential to provide.

Conclusion

This Commission should be commended for examining the complex issues associated with Medicaid and Medicaid financing. The charge, however, is an important one as Medicaid is a backbone of Maine's health care system and an important component of Dirigo Health.

Introduction

Maine has been a leader in health care reform, putting the issues of access, cost, and quality at the center of its policy agenda, but it is not alone in grappling with these important issues. A number of other states have adopted reforms; in just the past year Maine's neighbors in Massachusetts and Vermont have enacted broad-reaching plans and several other states have created commissions or undertaken studies to consider their options.

In every case where a state has expanded access to coverage as part of its health care reform initiative, the state has relied on the Medicaid program. The approaches vary, but Medicaid –in one form or another– is a constant factor. Medicaid offers enrollees comprehensive and affordable coverage, and, just as significant, it offers states federal matching payments to help finance their coverage efforts. For every $100 in state funds spent through Medicaid, Maine receives $170 in federal funds to help pay for the health care coverage and long term care services it provides to its residents. To translate the value of the federal support provided through Medicaid into coverage terms, if it costs $2,000 a year to cover an individual, and Maine has one million dollars in state funds to spend, 500 individuals can be covered. When the coverage is through Medicaid, the same one million in state dollars can cover nearly three times as many –1,350– people. (Table 1)

Table 1
Increased Coverage Through the Medicaid Structure

	State Funds	Federal Funds	Number of People Covered at $2,000 Per Person Cost
State Investment Without Medicaid Match	$1 million	$0	500
State Investment With Medicaid Match	$1 million	$1.7 million	1,350

Note: Assuming 63% Federal Match
Source: Georgetown Center for Children and Families

Medicaid –or MaineCare, as it is known in Maine– is a key component of Maine's health care system. This was the case before Dirigo, and it remains the case today under Dirigo. By integrating MaineCare into its broader initiative, Dirigo Health, Maine has the opportunity to benefit from Medicaid's federal financial support. This, in turn, creates the opportunity to offer coverage to more Mainers, reduce inequities among low-wage workers, and make coverage more accessible and affordable to employers and employees alike.

To help the Commission consider Medicaid's role within Dirigo Health, this report begins with a review of the basics of the Medicaid program, focusing on those features most relevant to Dirigo Health. It then considers how Dirigo Health and MaineCare

currently work together and some options for strengthening the existing structure. Finally, it examines other models (premium assistance and employer buy-ins) that some states have used to link Medicaid with employer funds and employer-based coverage. These approaches could be used in Dirigo Health, but, as described in the final section, they would bring in significantly less federal financial support than potentially will be available under the current structure.

I. Basic Facts about Medicaid

Medicaid is most commonly understood as a publicly-funded health insurance program for the poor. In fact, it is not quite that and at the same time it is much more than that.

Medicaid offers states federal payments for providing health care and long term care services to state residents, including many but not all of the poor, as well as more moderate income families with children, pregnant women, people with disabilities, and the elderly. Federal rules set out the groups of people that states must cover as a condition of participating in Medicaid while allowing states to extend coverage beyond these minimum requirements. Medicaid financing is intentionally structured to encourage and support optional state coverage initiatives. Federal funds are available to states without regard to whether a coverage group is required or optional, and there is no cap on the amount of federal funds available as long as the coverage provided meets minimum federal requirements. Every state participates in the Medicaid program, and every state has picked up at least some of the options to use Medicaid to cover groups and medical care beyond the minimum requirements.

Medicaid in Maine

According to the most recent state-level data available for all states, about 21 percent of nonelderly Mainers are covered by MaineCare, while 60 percent are covered by employer-based coverage, and 12 percent are uninsured.[1] The portion of residents insured through Medicaid in Maine is somewhat above the national average in part because the state has made greater use of Medicaid to cover low-income working families and very low-income adults without children than have many other states. Maine also appears to have a higher-than-average portion of people with disabilities enrolled in Medicaid, reflecting the fact that Maine has a relatively high percent of state residents with disabling conditions.[2] Not surprisingly, given their medical needs, as a group people with disabilities are among the most costly Medicaid enrollees; they account for about 25 percent of all MaineCare enrollees but their care consumes more than 40 percent of spending under the program.[3]

Largely as a result of the decisions Maine has made to make coverage available to many of its residents through Medicaid, Maine's uninsured rate is well below the national average. According to U.S. Census Bureau data, 12 percent of nonelderly Mainers were uninsured in 2003-2004, compared to 18 percent for the nation as a whole. Maine's uninsured rate for children is also well below the national average – 6 percent compared to 12 percent for the United States.[4]

These achievements are particularly notable in light of rising high health care costs and the fact that many of the businesses in Maine are small firms. Small firms are much less likely to offer health insurance to their workers largely for cost reasons. Nationally, firms with 200 or more workers are twice as likely to offer health benefits as firms with less than 10 workers.[5] Maine ranks 30th among the states in terms of employer offer rate; every other New England state besides Vermont is in the top seven while Vermont, which like Maine has many small firms, ranks 26th.[6] Maine's relatively low private coverage rate makes state coverage efforts particularly challenging –and its above-average coverage rates particularly notable.

Eligibility –Who can be covered under Medicaid?

As a condition of receiving federal Medicaid funds, every state must cover certain groups of people: low-income children and pregnant women, very low-income parents, and certain people with disabilities and elderly residents. States may extend coverage, at their option, to people at higher income levels as long as they fall within one of these groups (also known as "eligibility categories"). States may also raise or eliminate the resource (asset) test for any of these groups. For example, federal rules require all states to offer Medicaid to children under age six whose family income is below 133 percent of the federal poverty line ($1,840 a month for a family of three). Maine covers these children and also has opted to cover children with family incomes up to 150 percent of the poverty line. In addition, it has decided to not apply an asset test for children. (Maine further extends coverage to children with incomes between 150 and 200 percent of the federal poverty line under the State Children's Health Insurance Program, which Maine also calls MaineCare.[7])

While states have broad flexibility to expand coverage through Medicaid, for reasons that that have more to do with the historical underpinnings of the program than health care policy, federal Medicaid rules do not permit states to use Medicaid funds to cover adults who are not living with a child (and who are neither elderly, disabled or pregnant). This group of adults is not eligible for Medicaid no matter how low their incomes may be, unless a state has a special Medicaid "waiver." (Waivers are described below.) Maine does have a limited waiver to cover very low-income adults in this group – those with incomes below the federal poverty level who have no children or whose children are grown or not living at home. (This group is sometimes called the "noncategoricals" because they do not fit into any of the established Medicaid eligibility categories.)

The MaineCare income standards and asset rules for different eligibility groups are summarized in Table 2.

Table 2
MaineCare Income Eligibility and Asset Limits

Population	Income Eligibility Level	Asset Limit
Children under 19	200% FPL	No
Parents with children under 19	200% FPL	Yes
Adults without minor children	100% FPL	Yes
Disabled Adults	100% FPL	Yes

Note: Children in MaineCare with family incomes between 150-200% FPL are covered with SCHIP funds.
Source: MaineCare Services, 2006.

Benefits –What services can be covered under Medicaid?

States must cover a comprehensive set of services for children under federal Medicaid rules. They can also provide these benefits to adults or they can offer adults a more limited package. In all cases, services must be medically necessary for the particular individual in order to be covered. A new benefits option permitted under the federal Deficit Reduction Act of 2005 allows states to offer more restricted coverage to certain adults. The option can be applied to some groups of adults who were eligible under a state's Medicaid program before the federal law was enacted (February 8, 2006); it does not apply to new expansions.

Maine has picked up many of the optional benefits for adults while also deciding to not cover, or to limit, some of the medical services that it could offer adults under federal rules. Because of the low incomes of the people who are eligible for Medicaid and the high cost of most medical services, people enrolled in Medicaid often have difficulty paying for care that is not covered. If they receive care that Medicaid does not cover, the cost sometimes goes unpaid and is shifted onto health care providers or other payers. If they are able to pay, it is often at the expense of other basic necessities, such as rent, utilities, or gas.[8]

Delivery system - What type of systems can a state use to deliver Medicaid services?

This is a matter left largely to state discretion. Under federal rules, states can allow enrollees a broad choice of providers in either a fee-for-service or managed care setting or they can narrow the choices and require enrollment in managed care plans (subject to some exceptions). States can use different delivery systems for different groups of enrollees and in different parts of the state. Maine relies largely on fee-for-service arrangements in its MaineCare program (as it does in the private marketplace). Most health care providers participate in MaineCare, according to state officials. One change created by Dirigo Health is that the MaineCare enrollees who participate in Dirigo Health (like all Dirigo Health participants) are covered through managed care.

Payment rates – What rates do states pay health care providers who treat Medicaid enrollees?

Payment rates, like delivery systems, are also a matter left largely to state discretion. Within very broad requirements generally aimed at assuring access to care, federal rules leave Medicaid rate-setting decisions to the states.

Paying for coverage- How is Medicaid financed?

Medicaid is jointly financed by states and the federal government. Each state's share of the cost is determined by its federal "matching rate." The rate ranges between 50 percent (where the federal government and the state share costs equally) to 76 percent (where the federal government assumes a significantly greater share of costs). The rate is set

annually based on the state's relative per capita income; in general, less wealthy states receive more federal support.

Maine's federal Medicaid matching rate is 63.27 percent for federal fiscal year 2007 (which begins October 1, 2006).[9]

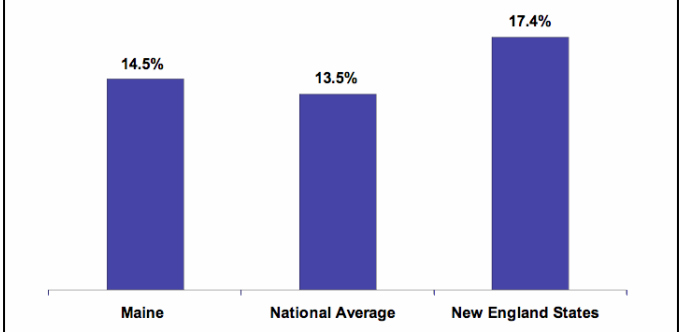
In part because Maine has used Medicaid to cover Mainers who would otherwise have no health insurance the program accounts for a significant share of state spending. According to data reported for all states by the National Association of State Budget Officers for Fiscal Year 2004, 14.5 percent of Maine's general and special funds were spent on Medicaid. This is pretty much in line with the national average and considerably lower than the New England average. NASBO reports show that on average states spent 13.5 percent of their general fund and other state funds on Medicaid in that year, while New England states spent, on average, 17.4 percent of their state funds on Medicaid.[10] (Figure 1)

The other side of the coin –and a particularly notable point given the charge of this Commission – is that Medicaid is the single largest source of federal funds for Maine. It accounts two-thirds of all federal funds received by the State, a significantly larger share than for the nation as a whole.[11] (Figure 2). As explained above, Medicaid brings in $170 in federal funds at for every $100 in state dollars Maine spends on program coverage, allowing the state to almost triple the reach of its health care dollars.

It is also significant, particularly given rising health care costs and declining employer-based coverage, that federal financing under Medicaid is not subject to a cap or pre-set limit. If a plant closing pushes up enrollment in MaineCare or if per person health care costs rise because of new technology or for other reasons, the federal government shares the additional cost with the State.

Figure 1

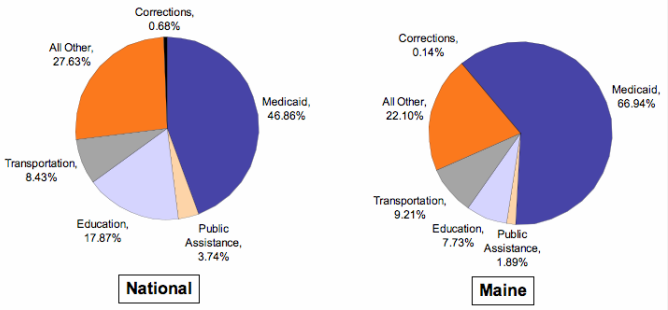
Medicaid Expenditures as a Percent of Total State Expenditures



Note: Expenditures include state general funds and state special funds; they do not consider federal fund expenditures.
Source: National Association of Budget Officer, 2004 State Expenditure Report, 2005.

Figure 2

Medicaid as a Share of All Federal Funds, U.S. and Maine, 2004



Note: "Education" includes elementary, secondary and higher education; and "All Other" varies by state and includes federal funds for the State Children's Health Insurance Program and may include a range of other federal funds such as economic development, housing, parks and recreation. Federal funds are calculated exclusive of capital expenditures.
Source: Georgetown Center for Children and Families analysis based on National Association of State Budget Officers (NASBO), 2004 State Expenditure Report, 2005.

(This central aspect of the Medicaid financing system does not apply if the services are provided under a Medicaid "waiver;" waivers are discussed in the section that follows.)

Changing the rules –How do Medicaid waivers work?

The basic rules described above can be modified by the Secretary of the U.S. Department of Health and Human Services (HHS) under so-called "Section 1115" waivers. Section 1115 of the Social Security Act grants the Secretary of HHS the authority to "waive" certain provisions of the Medicaid law and to let states receive federal funding for program expenditures that are "not otherwise matchable." In other words, under waivers states can receive federal funding even when the coverage provided does not conform to federal rules. (There are other types of waivers in Medicaid, most notably waivers that allow for greater investment in home and community-based long term care services. These narrower, targeted waivers are not discussed in this report.)

Section 1115 waivers are quite different from the regular state program options described above in two key ways (aside from the basic difference that waivers permit states to adopt program changes that are not otherwise allowed under the law). First, waivers are discretionary with the Secretary. The Secretary has broad discretion to decide whether or not to grant a waiver and to impose special terms as a condition of approval. By contrast, when a state seeks to implement a federal Medicaid option (e.g., extending coverage to more children or providing optional services to adults), the State must submit a "state plan" amendment to the federal government, but the amendment must be approved as long as the state is choosing an option permitted under the rules.[12] (In recent practice state plan amendments are sometimes held up in the process by CMS for reasons usually unrelated to the change, but the point remains that the Secretary cannot simply deny or add a special term to a state-proposed program change that is permitted by the law.)

The second major difference between options and waivers is that waivers must not result in any new costs for the federal government (this is referred to as "budget neutrality"). If a state decides to expand eligibility under an option, the initiative can —and typically does— result in additional federal costs. For example, when Maine decided to cover low-income children up to 150 percent of the federal poverty line, that optional MaineCare expansion resulted in some new federal costs. A section 1115 waiver, however, will not be approved unless the Secretary determines that the federal costs under the waiver will not exceed the costs the federal government would have incurred without the waiver. Therefore, if a state uses a waiver to cover a population it could not otherwise cover, the federal cost of that initiative must be offset by a reduction in federal costs elsewhere in the program. In addition, the federal government imposes a cap on its spending under all Section 1115 waivers to assure that federal costs are constrained.

The rules and the consequences of waiver financing are demonstrated clearly in Maine's waiver to cover so-called "non-categorical" adults (adults not living with dependent children who do not fit within any of the Medicaid eligibility "categories'). The cost to the federal government of this coverage initiative was offset by a reduction in other federal spending, and the federal government imposed a cap on the amount it would

spend for this new group. This fundamental departure from regular Medicaid financing rules has meant that from time to time since the waiver has been implemented, Maine has had to close MaineCare enrollment for this group of very poor adults. The alternative would be to shoulder the cost of covering additional eligible adults with state-only funds.

II. Dirigo Health and MaineCare

Dirigo's approach for integrating Medicaid into Maine's health reform efforts is described below followed by a discussion of possible ways this system could be strengthened. (This approach does not require a section 1115 waiver.)

Dirigo Health – the basic design

Dirigo Health combines public and private coverage in a unique and innovative way. Perhaps most simply put, it arranges coverage and provides premium discounts for eligible people who work in participating firms and their families. Sometimes that coverage is through MaineCare and sometimes it is outside of MaineCare. Dirigo Health is designed, however, to make these distinctions invisible to employers, employees, and providers.

The state's Dirigo Health Agency (DHA) contracts with employers to provide participating employees and their dependents with health coverage and other program services that meets certain specifications. DHA and the Department of Health and Human Services (DHHS), which administers the MaineCare program, each contract with Anthem Blue Cross of Blue Shield of Maine ("Anthem") to provide coverage that meets those specifications through a product called "DirigoChoice." In addition to arranging coverage, DHA is obligated to provide employees and their dependents with a discount on their cost of coverage, if they apply and are eligible.

Employees and family members whose income and assets fall within MaineCare eligibility levels are enrolled in Dirigo Health Group A, the group eligible for the steepest discount. Employers are not involved in determining discount levels nor are they informed of which discount level, if any, an employee qualifies for. DHA determines the appropriate discount level based on a discount application completed by employees that advises them that if they are eligible for a full discount they will be enrolled in Dirigo Health/MaineCare at no cost.

Adults and children enrolled in Group A are MaineCare enrollees as well as Dirigo Health enrollees; they receive coverage for medical care through the DHHS Anthem contract.[13] Employees and dependents that are not eligible for MaineCare are enrolled in one of the other Dirigo Health groups. They are offered a more limited discount or no discount depending on their income, and they receive coverage under the DHA Anthem contract. All Dirigo Health groups have access to the same provider network, and the payment levels to the participating providers are the same under both Anthem contracts

(consistent with the rates paid under Anthem Blue Cross and Blue Shield of Maine's commercial contracts).

Dirigo Health's design attempts to minimize any different treatment among employees, eliminate the inequities of the eligibility "cliff" that can result without a discount that slides up the income ladder, and assure continuity of coverage and stable provider relationships when an employee's income changes (up or down). For example, if an employee and her family are enrolled in Group A (Dirigo Health/MaineCare) and the employee receives a raise that puts the family over the MaineCare eligibility limits, the family will not lose their coverage nor will they have to change health plans or providers. The family will continue to be covered through DirigoChoice under the DHA Anthem contract rather than the DHHS Anthem contract. Significantly, they will probably still qualify for a substantial, although less steep, Dirigo Health discount (depending on their new income level).[14] In all likelihood, they will simply move within Dirigo Health from Group A (100 percent discount) to Group B (80 percent discount).

This approach also preserves the important role that Medicaid has played in Maine's effort to extend health care coverage to low-wage Mainers. By covering Dirigo Health employees and family members who are eligible for MaineCare in Dirigo Health/MaineCare, the state is able to claim federal matching payments for these individuals. This could relieve Dirigo Health of the full cost of providing the lowest income employees with a discount that is sufficiently deep to allow them to participate. Since employers make contributions for all participating employees, regardless of eligibility for DirigoChoice/MaineCare or any other discount group, all workers are treated alike at the workplace, and the contributions add to the state funds available to support the overall initiative. This arrangement has not required a waiver because Maine is not changing the basic MaineCare rules. DHHS and the Centers for Medicare and Medicaid services ("CMS," the federal agency that oversees Medicaid) continue to be in discussion about Maine's approach to integrating Medicaid into a broader health reform initiative.

Dirigo Health- Options for moving forward

There are many important advantages to the current relationship between Dirigo Health and MaineCare. However, the system is not deriving all of the benefits it could from this structure because there are so few Group A enrollees. According to DHA data, in July, 2006, Group A enrollment accounted for only one percent of all of Dirigo enrollees, while Group B, the group with the next highest discount level, accounted for nearly half of all Dirigo Health enrollees.[15] This is well below expected levels of Group A enrollment, given MaineCare eligibility levels and the income levels of Mainers.[16] This skewed distribution could be due to any number of factors. The options below offer suggestions for addressing possible reasons for the low Group A enrollment; more analysis is needed to assess whether these or other options could help move the initiative forward.

- *Boosting participating rates in Group A through improved marketing and enrollment procedures*

While the intent of the Dirigo Health design is to make it easy for people to enroll and be assigned to the appropriate discount group, the numbers suggest that some people who are eligible for Group A may be enrolling in Group B instead or they may be enrolling separately in MaineCare outside of the Dirigo Health initiative. The relatively low Group A enrollment may be due to any number of factors, such as:

  - The marketing of Dirigo Health and/or the take up by employers could, for any number of reasons, be skewed more toward firms with somewhat higher income workers (workers with family incomes above MaineCare/Group A eligibility standards).

  - Some employees might be dissuaded from pursuing eligibility for Group A, despite the deeper discount if producers and others working with potential enrollees do not fully or properly explain the benefits of providing the information necessary to qualify for Group A. If this occurs, employees are losing out on the steeper discount and the broader benefits available to Group A enrollees and the state could be losing out on potential federal matching payments that could reduce the overall cost of the initiative.

  - Some workers whose employers sign up for Dirigo Health may be already enrolled in MaineCare (and therefore do not sign up as part of Dirigo Health) or employers or producers may be encouraging workers who believe they may be eligible for MaineCare to enroll directly without participating in the Dirigo Health.

Inquiries with Dirigo Health partners and stakeholders, surveys, and other analyses could be undertaken to determine whether and to what extent these or other factors are at play to any significant degree. If any of these or related factors are problems, a variety of approaches could be developed to assure that people are enrolled in the group most appropriate to their circumstances.

- *Changing asset rules or procedures*

One possible reason for small portion of Group A enrollees is that the income or resource limits imposed in the MaineCare program may be keeping low-wage workers (and/or their dependents) from qualifying for the deepest discount (Group A). Considering Maine and other states' experience covering children, the first place to look may be the asset rules.

As described above, MaineCare has an asset limit for adults; the limit is part of the DHHS rules that apply to MaineCare, not just to Dirigo Health/MaineCare. In order to

qualify for Dirigo Health/MaineCare (Group A), employees must establish that their resources (e.g., bank accounts, cash on hand, property) have a total value that is below the limit. Currently, there is no asset test for any other Dirigo Health discount group (or for children in Group A), so the asset rules apply only to adults who may be eligible for Group A. The asset limit is set at $2,000 but it has certain exclusions and special rules that help people to qualify (for example, a family's principle residence and car are exempt, and a second car is excluded under some circumstances),[17] but still the test is likely to screen out some low-wage workers.

A closely related issue that might be causing people to end up in Group B instead of Group A is that the asset rules may be confusing and the process for verifying that an employee or family meets the asset requirement may be difficult or time consuming. Indeed, even the discount calculator, a tool that DHA developed to allow individuals to estimate potential discount levels, does not permit people to test whether they are eligible for the Group A discount.[18] In part, this is because it is difficult to explain the different asset rules.

If people are deterred from establishing their eligibility for Group A because of complicated rules and paperwork, they may be falling into Group B by default. When this occurs, those individuals are paying more for their coverage than they may be able to afford and sustain, and, since they are not enrolled in Group A, the state cannot claim any federal matching payment on their behalf. Studies looking at the asset limit for children in Medicaid and SCHIP have found that the *process* of identifying and proving the value of assets can be a real barrier to enrollment in coverage programs. Almost all states, including Maine, have dropped the asset test for children, and nine of the 15 states (other than Maine) that have expanded Medicaid coverage to low-income working parents have no asset test for parents as well as children.[19]

If the asset test is determined to be a barrier that keeps people from qualifying for Group A (Dirigo Health/MaineCare), Maine has a number of options.

- It could eliminate the asset test for adults (or for just for the parent group) and only consider income (as it currently does for children and for the adults in the other Dirigo discount groups);

- It could raise the asset limit or expand the kinds of resources it excludes from consideration;

- It could retain an asset test (as is, or modified), but alter the way it asks about and verifies assets (for example, by allowing self-declaration of assets and then doing computer bank matches and other audits to ensure program integrity).

Under federal law, these are all options available to Maine. It is important to note, however, that Maine probably could not eliminate or raise the Group A asset test for Dirigo Health/MaineCare applicants without taking the same step for individuals in

similar circumstances who might apply for MaineCare directly through DHHS, except through a waiver. Such a change, therefore, could have coverage implications, and an operational and fiscal impact beyond Dirigo Health that would need to be explored. (It is possible, without a waiver, to use different approaches to verify assets for different groups of MaineCare beneficiaries.)

In the short term, it would be useful to explore whether and how the asset test may be impacting Group A enrollment and to weigh the potential savings of eliminating or modifying the asset test for Dirigo Health against the potential added cost of taking this step for MaineCare parents more broadly.

III. Other Approaches- Premium Assistance and Medicaid Buy-ins

Premium Assistance –The Basic Design

Premium assistance represents a very different approach for integrating public and private coverage than the one used in Dirigo Health. Under a premium assistance model (there are many possible variations), a state uses Medicaid funds to pay the employee's share of private insurance (typically employer-sponsored insurance). Several states have implemented a premium assistance program, although typically enrollment has been quite limited.[20]

Under the basic approach, if a Medicaid-eligible individual has access to private insurance a state can require the individual to purchase the employer plan as a condition of enrolling in Medicaid. In this situation, Medicaid pays the individual's share of the cost of the premium (less any premiums that the Medicaid program itself may impose), and it picks up the copayments or deductibles required by the private policy that exceed those allowed under the state's Medicaid program. In addition, the individual is provided Medicaid coverage for services that are not covered by the private plan if they are covered under the state's Medicaid program. In other words, the employer-based plan is the first payer but the Medicaid program is obligated to assure that enrollees are no worse off in terms of costs and coverage than they were enrolled only in Medicaid. [21]

Only a few states have premium assistance programs of any significant size. This is partly because only a small portion of the low-income individuals who are eligible for Medicaid have access to a sufficiently broad employer-sponsored plan with a large enough employer contribution to make the public investment in the private plan cost effective. Take up among states has also been dampened to some degree because the administrative tasks associated with paying the premiums in an ever-changing market and with federal rules that require states to assess the value of the plan and wrap around the coverage can be burdensome. Rhode Island has one of the largest premium programs in the country, but despite its relative success its program accounts for less than five percent of its overall Medicaid enrollment.[22]

Employer Buy-ins- the basic design

Another, similar approach to marrying public and private coverage is to allow employers to use the Medicaid program as a possible insurance product. Employers could purchase the Medicaid coverage package and make it available to their employees regardless of Medicaid eligibility. Under this basic design, there would be no federal match for this type of initiative; it simply makes a potentially more affordable plan available to employers who are priced out of the standard market.

A few states, including Maine, allow individuals to buy into Medicaid or the State Children's Health Insurance Program, but it does not appear that any state has designed an option that allows employers to buy into the regular Medicaid program or SCHIP as a way to offer relatively lower cost coverage to its workers. Two states, however, have developed variations on this approach through section 1115 waivers.

New Mexico created a plan with limited benefits and higher cost sharing than the state offers through its regular Medicaid program. The goal of the initiative is to market the new product to employers who had not been offering coverage to their workers to encourage more firms to provide coverage. An employer can purchase the plan at a cost of $75 per member per month for any adult worker whose income is below 200 percent of the federal poverty line (about $2,800 a month for a family of three). The eligible employee also pays a premium depending on income (those under poverty are not charged a premium). Adults whose employers do not join can purchase the plan without employer participation; in this situation, the enrollee pays the employer and the employee cost (if any). Under the waiver, the federal government shares the cost state's cost, net of any contribution from the employer or employee. According to state administrators, after one year, participation is about 5,000, below projections.

Arkansas also has a waiver to market an even more limited benefit plan to employers. The plan was approved in March 2006 and coverage is set to be effective January 2007.

Since both of these plans were approved through section 1115 waivers, it is important to note their special financing terms. The New Mexico waiver initiative is financed through the state's SCHIP allotment (the cap on SCHIP funds operates as the budget neutrality cap)**.** This is not a viable funding source for a Maine initiative since Maine has no surplus federal SCHIP funds. Arkansas's waiver achieves budget neutrality for the federal government in part by requiring an offset in other federal Medicaid spending under the state's program and by imposing a per person cap on federal expenditures for *all* enrollees under the state's Medicaid program (i.e., the cap extends well beyond the newly covered group).[23] Over time, this cap could prove to be a significant constraint for Arkansas.

Premium Assistance and Buy-ins -- Options for Maine

It is important to put these options into context as Maine considers how to move forward with its coverage initiatives. Using the premium assistance model in MaineCare but

outside of Dirigo Health raises different issues than using it as a model for restructuring the relationship between MaineCare and Dirigo Health. While this Commission is concerned with Dirigo Health, it is important to be clear about the different approaches..

Consider first the option of relying on premium assistance outside of Dirigo Health. Maine already has a very small premium assistance program (less than 200 people are enrolled according to state officials), and it could decide it would be helpful to increase that number. A recent analysis by the State's Department of Health and Human Services showed that 54,000 people enrolled in MaineCare work for companies that offer coverage, reflecting the fact that as MaineCare has grown a significant portion of MaineCare enrollees are employed (or, in the case of children, their parents are working). This number is just a starting point for considering whether a more aggressive premium assistance program makes sense for Maine, since some people working at these firms will not be eligible for the job-based coverage (e.g., they work part time or have not worked long enough for the firm) and information on the cost of the employer benefits is not available. Nonetheless, it suggests that beefing up Maine's premium assistance program outside of Dirigo Health may be worth considering. With concerted effort, states like Rhode Island have realized savings from their premium assistance programs.[24] (Rhode Island has also assured that it only invests in plans that are cost effective for the state; this is an important part of the strategy that is sometimes missing from other premium assistance programs.)

Thinking about applying the premium assistance (or Medicaid buy-in) models within the context of Dirigo Health's goals and objectives raises other issues. Instead of potentially saving funds, applied in Dirigo Health these models could result in added costs for Dirigo.

Under a premium assistance or employer buy-in model participating employers would purchase an insurance plan from the Dirigo Health Agency and if an employee or their dependent applied for or was already receiving MaineCare, MaineCare could pay for the employee's share of the premium and potentially provide wrap around benefits and help with cost sharing. Maine could adopt the premium assistance approach at state option (i.e., no waiver is required) as long as it provided the wrap around assistance on benefits and cost sharing. A waiver would be required if the state sought to limit coverage to the basic Dirigo benefit plan.

The cost implications arise because premium assistance or buy-in approaches provide states with a limited federal matching payment (relative to regular MaineCare coverage). An example may help illustrate the financing consequences of converting Dirigo Health to a premium assistance model. Assume that the total per person cost of coverage is $2,000 a year and the coverage is provided directly through MaineCare or through Dirigo Health/MaineCare (Group A). The federal government's share is 63 percent of the total cost or $1,260. (As noted above, the federal payments for Group A are currently under federal review.). Under premium assistance or an employer buy-in approach, the federal government shares the cost net of the employer contribution. If the

employer pays half of the cost of the $2000 policy, the federal government would pay $630 instead of $1,260 toward the cost of coverage.

Given these financing rules, if Maine converted the system to a premium assistance model where MaineCare picked up the employee share of the coverage cost for those Dirigo Health employees and dependents that were eligible for MaineCare, it would receive a significantly lower matching payment than it is now claiming under the current Dirigo Health model.

Conclusion

Medicaid is a key component of every state's health care reform initiative, and it is a key component of Maine's Dirigo Health initiative. There are many ways to structure the relationship between Medicaid and employer-based coverage efforts, and it is useful to consider how each of those different designs would further Maine's efforts to control costs, improve quality, and assure access to care.

Maine has developed an innovative approach that meets a number of important objectives. However, it is not realizing the full benefits from this approach. Further refinement may strengthen the system. Other approaches, such as premium assistance are possible, but do not provide the same level of federal support that the current structure has the potential to offer. Premium assistance may be considered outside of Dirigo Health or possibly at a later time. Either way, MaineCare needs to remain a strong partner with Dirigo Health to help the State meet its broader health reform goals.

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[1] These data are from the Current Population Survey (CPS) for 2003-2004. Note that some people have more than one source of coverage; for example, some people may have employer-based coverage and Medicaid or they may have Medicare as well as Medicaid coverage. These data count anyone with Medicaid coverage as being a Medicaid enrollee.

[2] Centers for Disease Control, *Prevalence Data: Disability 2005;* http://apps.nccd.cdc.gov/brfss/list.asp?cat=DL&yr=2005&qkey=4000&state=All; U..S. Census Bureau, *Disability 2000*, http://www.census.gov/prod/2003pubs/c2kbr-17.pdf;

[3] The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006.

[4] StateHealthFactsonline.org.

[5] *Employer Benefit Survey, 2005 Annual Survey*, Kaiser Family Foundation and HRET September 2005.

[6] *Percent of Private Sector Establishments that Offer Health Benefits*, data from the Medical Expenditure Survey as reported on StateHealthFactsonline.org.

[7] The State Children's Health Insurance Program was established at the federal level in 1997 and implemented in Maine the following year. SCHIP provides states with federal funding to expand coverage to children either through a separate child health program or through Medicaid.

[8] G. LeCouteur, M. Perry, S. Artiga and D. Rousseau. *The Impact of Medicaid Reductions in Oregon: Focus Group Insights.* Kaiser Commission on Medicaid and the Uninsured, December 2004. C. Williams, J. Rosen, J. Hudman, M. O'Malley. *Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage.* The Kaiser Commission on Medicaid and the Uninsured, April 2004. C. Pryor, and M. Monopoli. *Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience.* Kaiser Commission on Medicaid and the Uninsured, September 2005.
[9]The rates are set each year by the U.S. Department of Health and Human Services. http://aspe.hhs.gov/health/fmap07.htm. Maine receives a higher matching rate - 74.29 percent– for spending under the State Children's Health Insurance Program (covering children with family incomes between 150 and 200 percent of the poverty line). SCHIP matching rates are based on but more favorable than the Medicaid matching rates to encourage states to expand coverage to children.
[10] Several factors likely explain the higher spending levels in New England, including somewhat higher regional health costs, and, for all states other than Maine, somewhat lower-than-average federal matching rates..
[11] *State Expenditure Report 2004*. National Association of Budget Officers (2005). The NASBO analysis considers all federal funds received directly by the state; it does not count federal benefits received directly by individuals or businesses.
[12] Each state operates under a state Medicaid "plan." This is a document that a state submits to the federal agency that oversees the Medicaid program (the Centers for Medicare and Medicaid Services which is part of the U.S. Department of Health and Human Services) in which the state notes which options it has chosen to adopt. States inform CMS of any change in its plan by submitting a "State Plan Amendment" ("SPA"). Although CMS reviews the SPAs, approval must be granted if a state has proposing to implement an option that is available under federal law. The details of the state plan amendment and approval process is described in Robin Rudowitz & Andy Schneider. *The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act.* Kaiser Commission on Medicaid and the Uninsured, August 2006.
[13] Because DirigoChoice does not cover all of the medical care covered under MaineCare, the Group A Dirigo Health participants are also covered for additional "wrap around" services on a fee-for-service basis.
[14] Under Medicaid rules, families who become ineligible for Medicaid due to earnings can continue to receive Medicaid for a transitional period (up to 12 months). After that, each family member's eligibility for Medicaid is separately evaluated.
[15] "Dirigo Health Monthly Numbers July 2006," Dirigo Health Agency, August 2, 2006.
[16] Parents and children now qualify for MaineCare if their family income is below 200 percent of the poverty line; in 2003-2004, about one in four Mainers had incomes below this income level. The MaineCare eligibility rules do, however, impose an asset test for parents and other adults (not for children) which would narrow the eligibility pool (the asset test is discussed more below). About 19 percent of all Maine children and 13 percent of adults in Maine between the ages of 19 and 64 have incomes below the federal poverty level. These data is based on estimates prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured based on the U.S. Census Bureau's March 2004 and 2005 Current po0ulation Survey ("CPS").
[17] MaineCare Eligibility Manual, section 2200. http://www.maine.gov/sos/cec/rules/10/ch332.htm
[18] See, http://www.Dirigo Health.maine.gov/dhsp02c.html.
[19] Of the 15 states (in addition to Maine) that have expanded eligibility to parents up to at least 100% of the federal poverty line, nine states have no asset test for parents, four states have an asset test of between $3,000 and $6,000, one has a $20,000 asset test and one has a $2,500 asset test. Center for Children and Families analysis of the data presented in *a time of Growing Need: State Choices Influence Health coverage Access for Children and Families*, prepared by Donna Cohen Ross and Laura Cox, Center for Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. October 2005. The data is from a survey of states conducted in the summer of 2005.
[20] For a discussion of premium assistance, see Cynthia Shirk and Jennifer Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?*, National Health Policy Forum Issue Brief No. 812, July 17, 2006; Joan Alker, *Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity*, Kaiser Commission on Medicaid d and the Uninsured, October 2003,
[21] A waiver could dispense with the obligation to offer the benefit wrap or to fill in for additional cost sharing or premium costs. This approach further limits state costs (and federal matching payments) but by

shifting those costs (or the risk of unmet health care needs) onto low-income individuals or onto others as uncompensated care. A few states, including New Jersey, Oregon, and Utah have such waivers. Illinois's waiver takes a somewhat different tact by offering individuals the choices of the more limited premium assistance coverage through the individual's employer (if such coverage is offered by the employer) or direct Medicaid coverage. Eligible individuals can switch at any time.

[22] Enrollment as of April 30, 2006 from *RIteCare RIteShare Annual Report 2005*.

[23] Centers for Medicare and Medicaid Services, Special Terms and Conditions, Arkansas Safety Net Benefit Program, Section XIV. The waiver also imposes certain restrictions on the funds Arkansas can use as its state match and specifically rejects Arkansas' request to use employer contributions as its state match. Arkansas' proposed plan and financing arrangement was quite different from the coverage and financing arrangements under Dirigo Health.

[24] In its *2004 Annual Medicaid Report,* Rhode Island noted that the average cost of its premium assistance program was $119 per member per month compared to $206 for its other Medicaid enrollees. It makes sense that the costs of its premium assistance program are lower than regular Medicaid since the state only enrolls individuals in premium assistance if it finds it is cost effective to do so.